MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*
INTERRUPTED STAY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	**LEGAL NAME OF PATIENT**	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Suffix)
2.	**ADMISSION DATE**	**a.** *Date the stay began* (*date of initial admission*) Month — Day — Year **b.** *Date Medicare covered Part A stay began — If different than* ***AA2a*** Month — Day — Year
6.	**SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non Med. no.]**	**a.** Social Security Number **b.** Medicare number (or comparable railroad insurance number)
7.	**MEDICAL RECORD NO.**	
8.	**FACILITY PROVIDER NO.**	**a.** State No. **b.** Federal No.
9.	**MEDICAID NO.**	[***"+" if pending, "N" if not a Medicaid recipient***]
10.	**GENDER**	1. Male 2. Female
11.	**BIRTHDATE**	Month — Day — Year
12.	**ETHNICITY/ RACE**	(***CHECK all that apply***) ***ETHNICITY*** Hispanic or Latino ***RACE*** American Indian/Alaskan Native **a.** Black or African American **b.** White Asian — **c.** Native Hawaiian or other Pacific Islander — **d.** **e.** **f.**
13.	**INTERRUPTED STAY**	**a.** *Date/time departed from the rehabilitation unit/hospital* Month — Day — Year; Hours — Minutes — AM/PM **b.** *Date/time returned to the rehabilitation unit/hospital* Month — Day — Year; Hours — Minutes — AM/PM
14.	**CLINICIAN COMPLETING ASSESSMENT**	**a. SIGNATURE OF CLINICIAN ATTESTING TO THE ACCURACY OF THE DATES THE PATIENT DEPARTED FROM AND RETURNED TO THE REHABILITATION UNIT/HOSPITAL** Printed Name **b.** (First) **c.** (Middle Initial) **d.** (Last) **e.** (Suffix) **f.** Credentials: 1. Physician 2. Registered nurse 3. Physical therapist 4. Occupational therapist

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*

• Assessment reflects activities *OVER LAST 3 DAYS* unless otherwise indicated

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1. LEGAL NAME OF PATIENT

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Suffix)

2. ADMISSION DATE

a. *Date the stay began* (*date of initial admission*)

Month — Day — Year

b. *Date Medicare covered Part A stay began — If different than* ***AA2a***

Month — Day — Year

3. REASON FOR ASSESSMENT

1. Admission (covers first 3 days, completed on day 4)
2. Reassessment completed on day 11
3. Reassessment completed on day 30
4. Reassessment completed on day 60
5. Discharge assessment completed day 5 after discharge

4. ASSESSMENT REFERENCE DATE

Assessment reference date—last day of the 3-day MDS-PAC observation period

Month — Day — Year

5. DISCHARGE STATUS

a. *Last day of stay*

Month — Day — Year

b. *If discharged, status at discharge*

0. Rehabilitation program complete for this stay and return not anticipated
1. Patient left, against medical advice, prior to completion of plan of care
2. Acute problem, discharge to acute hospital
3. Patient died

6. SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non Med. no.]

a. Social Security Number — — —

b. Medicare number (or comparable railroad insurance number)

7. MEDICAL RECORD NO.

8. FACILITY PROVIDER NO.

a. State No.

b. Federal No.

9. MEDICAID NO.

["+" if pending, "N" if not a Medicaid recipient]

10. GENDER

1. Male 2. Female

11. BIRTHDATE

Month — Day — Year

12. ETHNICITY/ RACE

(***CHECK all that apply***)

ETHNICITY

Hispanic or Latino

RACE

American Indian/Alaskan Native

Asian

a. Black or African American

Native Hawaiian or other Pacific Islander

b. White

c. d. e. f.

SECTION AB. ASSESSMENT ATTESTATION

1. PERSON COMPLETING ASSESSMENT

a. SIGNATURE OF CLINICIAN ATTESTING TO COMPLETION OF ASSESSMENT:

Printed Name

b. (First) **c.** (Middle Initial) **d.** (Last) **e.** (Suffix)

f. Credentials: 1. Physician 2. Registered nurse 3. Physical therapist 4. Occupational therapist

g. Date MDS-PAC signed as complete

Month — Day — Year

2a. Signatures of staff completing part of the assessment	Credentials	Sections	Date
b.			Date
c.			Date
d.			Date
e.			Date
f.			Date

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*
FULL ASSESSMENT FORM (ASSESSMENT, REASSESSMENT, DISCHARGE)

SECTION A. DEMOGRAPHIC/ADMISSION INFORMATION HISTORY

- **Assessment reflects activities *OVER LAST 3 DAYS* unless otherwise indicated**

1. LEGAL NAME OF PATIENT
a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Suffix)

2. ADMISSION DATE
a. *Date the stay began* (*date of initial admission*)
Month — Day — Year
b. *Date Medicare covered Part A stay began — If different than* ***A2a***
Month — Day — Year

3. REASON FOR ASSESSMENT
1. Admission (covers first 3 days, completed on day 4)
2. Reassessment completed on day 11
3. Reassessment completed on day 30
4. Reassessment completed on day 60
5. Discharge assessment completed day 5 after discharge

4. ADMISSION STATUS
0. First admission to inpatient rehabilitation services
1. Readmission to rehabilitation but not directly from other rehabilitation
2. Readmission directly from other rehabilitation

5. GOALS FOR STAY
***CODE indicate all that apply*:** 0. No 1. Yes
a. Medical stabilization
b. Rehabilitation/Functional improvement
c. Recuperation
d. Monitoring to avoid clinical complication
e. Palliative care

6. ADMITTED FROM (At date of admission—A2)
1. Private home
2. Private apartment
3. Rented room
4. Board and care/group home
5. Assisted living
6. Homeless shelter
7. Transitional living
8. Long term care facility (nursing home)
9. Post acute care SNF
10. Acute care hospital—not rehabilitation unit
11. Rehabilitation unit (in acute hospital)
12. Rehabilitation hospital
13. Long term care hospital
14. Psychiatric hospital/unit
15. MR/DD facility (exclude group home)
16. Other hospital
17. Outpatient surgery center
18. Other

7. PRECIPITATING EVENT PRIOR TO ADMISSION
a. ***Time of the onset of the precipitating event/problem*** *that directly preceded admission into this facility* (*time from date of admission—****item A2***)
0. Within last week
1. Within last 8 to 14 days
2. 15 to 30 days ago
3. 31 to 60 days ago
4. More than 60 days ago

b. *Date of admission of most recent acute hospitalization* (***within last 90 days***)
Month — Day — Year

c. *Reason for most recent acute care hospitalization* (***within last 90 days***)
0. Not hospitalized at any time in **last 90 days**
1. New problem
2. Exacerbation
3. Both

8. PRIMARY AND SECONDARY PAYMENT SOURCE FOR STAY
0. None - No insurance coverage, no private pay
1. Medicare
2. Medicaid
3. CHAMPUS
4. Department of Veterans Affairs
5. Managed care/HMO—Medicare
6. Managed care/HMO—non-Medicare
7. Private insurance
8. Private pay—self or family
9. Workers' compensation
10. Other payment
A Prim **B Sec**

9. MARITAL STATUS
1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

10. EDUCATION (*Highest Level Completed*)
1. No schooling
2. 8th grade/less
3. 9th-11th grade
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

11. LANGUAGE
a. *Primary Language*
0. English 1. Spanish 2. French 3. Other, specify in **A11b**
b. ***If other, specify***

12. DOMINANT HAND
1. Right 2. Left 3. Unable to determine

13. MENTAL HEALTH HISTORY
Patient's RECORD indicates history of mental retardation, mental illness, or developmental disability problem
0. No 1. Yes

14. CONDITIONS RELATED TO MR/DD STATUS
1. Not applicable—no MR/DD
2. MR/DD with no organic condition
3. MR/DD with organic condition

15. RESPONSIBILITY/ LEGAL GUARDIAN
(***CHECK all that apply***)
Legal guardian **a.**
Other legal oversight **b.**
Durable power of attorney/health care proxy **c.**
Patient responsible for self **d.**
NONE OF ABOVE **e.**

16. ADVANCE DIRECTIVES
(***CHECK all that apply*** *that have supporting* ***documentation***)
Living will **a.**
Do not resuscitate **b.**
Do not hospitalize **c.**
Treatment restrictions **d.**
NONE OF ABOVE **e.**

SECTION B. COGNITIVE PATTERNS

1. COMATOSE
Persistent vegetative state/no discernible consciousness
0. No 1. Yes (**IF YES, SKIP TO SECTION E**)

2. MEMORY/ RECALL ABILITY (Over last 3 days)
(***CODE for recall of what was learned or known***)
0. Memory OK 1. Memory problem
a. Short-term memory OK—Seems/appears to recall after 5 minutes
b. Long-term memory OK—Seems/appears to recall long past
c. Situational memory OK—**Both**: recognizes staff names/faces frequently encountered **AND** knows location of places regularly visited (bedroom, dining room, activity room, therapy room)
d. Procedural memory OK—Can perform all or almost all steps in a multitask sequence without cues for initiation

3. COGNITIVE SKILLS FOR DAILY DECISION MAKING (Over last 3 days)
a. *Making decisions regarding tasks of daily life*
0. *INDEPENDENT*—Decisions consistent/reasonable/safe
1. *MODIFIED INDEPENDENCE*—Some difficulty in new situations only
2. *MINIMALLY IMPAIRED—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times*
3. *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times
4. *SEVERELY IMPAIRED*—Never/rarely made decisions

b. *Is* ***now more impaired*** *in decision making than prior to precipitating event (item* ***A7a****)*
0. No or unsure 1. Yes, more impaired today

4. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (Over last 7 days)
(***CODE for behavior in the last 7 days.***) [***Note: Accurate assessment requires conversations with staff and family who have direct knowledge of patient's behavior over this time***].
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from patient's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

SECTION C. COMMUNICATION/VISION PATTERNS (Over last 3 days)

1. HEARING
With hearing appliance, if used
0. *HEARS ADEQUATELY*—No difficulty in normal conversation, social interaction, TV, phone
1. *MINIMAL DIFFICULTY*—Requires quiet setting to hear well
2. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to increase volume and speak distinctly
3. *HIGHLY IMPAIRED*—Absence of useful hearing

2. MODES OF COMMUNICATION
(***CHECK all used by patient to make needs known***)
Hearing aid **a.**
Lip reading **b.**
Signs/gestures/sounds **c.**
Writing messages to express or clarify needs **d.**
NONE OF ABOVE **e.**

3. MAKING SELF UNDERSTOOD (Expression)
a. *Expressing information content—however able*
0. *UNDERSTOOD*—Expresses ideas without difficulty
1. *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts *BUT* if given time, little or no prompting required
2. *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usually required
3. *SOMETIMES UNDERSTOOD*—Ability is limited to concrete requests
4. *RARELY/NEVER UNDERSTOOD*

b. *Is* ***now more impaired*** *in making self understood by others than was prior to precipitating event (item* ***A7a****)*
0. No or unsure 1. Yes, more impaired today

4. SPEECH CLARITY

0. *CLEAR SPEECH*—Distinct, intelligible words
1. *UNCLEAR SPEECH*—Slurred, mumbled words
2. *NO SPEECH*—Absence of spoken words

5. ABILITY TO UNDERSTAND OTHERS (Comprehension)

a. *Understanding verbal information content* (*however able*) *with hearing appliance, if used*

0. *UNDERSTANDS*—Clear comprehension
1. *USUALLY UNDERSTANDS*—Misses some part/intent of message *BUT* comprehends most conversation with little or no prompting
2. *OFTEN UNDERSTANDS*—Misses some part/intent of message, with prompting can often comprehend conversation
3. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication only
4. *RARELY/NEVER UNDERSTANDS*

b. *Is* ***now more impaired*** *in understanding others than was prior to precipitating event (item* ***A7a****)*
0. No or unsure 1. Yes, more impaired today

6. VISION

a. *Ability to see in adequate light and with glasses, if used*

0. *ADEQUATE*—Sees fine detail, including regular print, in newspaper/books
1. *IMPAIRED* —Sees large print, but not regular print in newspapers/books
2. *MODERATELY IMPAIRED* —Limited vision; not able to see newspaper headlines, but can identify objects
3. *HIGHLY IMPAIRED* —Object identification in question, but eyes appear to follow objects
4. *SEVERELY IMPAIRED* —No vision, eyes do not appear to follow objects BUT may report seeing light or colors only

b. *Is* ***now more impaired*** *in vision than was prior to precipitating event (item* ***A7a****)*
0. No or unsure 1. Yes, more impaired today

SECTION D. MOOD AND BEHAVIOR PATTERN

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (Over last 3 days)

(***CODE for indicators observed in last 3 days, irrespective of the assumed cause***)

0. Indicator not exhibited in last 3 days 2. Exhibited on each of last 3 days
1. Exhibited on 1-2 of last 3 days

VERBAL EXPRESSIONS OF DISTRESS

a. PATIENT MADE NEGATIVE STATEMENTS—(e.g., "*Nothing matters; Would rather be dead than live this way; What's the use; Let me die*")

b. PERSISTENT ANGER WITH SELF OR OTHERS—(e.g., easily annoyed, anger at presence in post acute care, anger at care received)

c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS—(e.g., fear of being abandoned, left alone, being with others, afraid of nighttime)

d. REPETITIVE ANXIOUS COMPLAINTS/CONCERNS (non-health related)—(e.g., persistently seeks attention/reassurance regarding therapy or others' schedules, meals, laundry, clothing, relationship issues, when family will visit)

e. REPETITIVE HEALTH COMPLAINTS—(e.g., persistently seeks medical attention, obsessive concern with body functions, obsessive concern with vital signs)

SAD, APATHETIC, ANXIOUS APPEARANCE

f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS—(e.g., furrowed brows)

g. CRYING, TEARFULNESS

h. REPETITIVE PHYSICAL MOVEMENTS—(e.g., pacing, hand wringing, restlessness, fidgeting, picking)

SLEEP CYCLE ISSUES

i. INSOMNIA/CHANGE IN USUAL SLEEP PATTERNS

LOSS OF INTEREST

j. WITHDRAWAL FROM ACTIVITIES OF INTEREST—(e.g., no interest in long standing activities or being with family/friends)

k. REDUCED SOCIAL INTERACTION—(e.g., less talkative, more isolated)

2. MOOD PERSISTENCE (Over last 3 days)

One or more indicators *of depressed, sad or anxious mood* ***were not easily altered by attempts to "cheer up," console, or reassure the patient over last 3 days***

0. No mood indicators or always easily altered
1. Partially altered or easily altered on only some occasions
2. All aspects of mood not easily altered

3. BEHAVIORAL SYMPTOMS (Over last 3 days)

(***CODE*** *for behavioral symptom* ***frequency over the last 3 days***)
0. Behavior not exhibited in last 3 days
1. Behavior of this type occurred on 1 day
2. Behavior of this type occurred on 2 days
3. Behavior of this type occurred daily

a. WANDERING—Moved (locomotion) with no rational purpose, seemingly oblivious to needs or safety

b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS—Others were threatened, screamed at, cursed at

c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS—Others were hit, shoved, scratched, sexually abused

d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS—Made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings

e. RESISTS CARE—Resisted taking medications/injections, ADL assistance, eating, or changes in position

SECTION E. FUNCTIONAL STATUS

1. 3 DAY ADL SELF-PERFORMANCE—(*CODE for Performance Over All Shifts, for All Episodes, OVER LAST 3 DAYS*) [NOTE - for *Bathing and Tub Transfer,* code for most dependent single episode in this period]

0. *INDEPENDENT*—No help, setup, or supervision —OR— Help, setup, or supervision provided only 1 or 2 times during period (with any task or subtask)

1. *SETUP HELP ONLY*—Article or device provided or placed within reach of patient 3 or more times

2. *SUPERVISION*—Oversight, encouragement or cuing provided 3 or more times during period —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for a total of 3 or more episodes of help or supervision)

3. *MINIMAL ASSISTANCE* (*LIMITED ASSISTANCE*)—Patient highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)

4. *MODERATE ASSISTANCE* (*EXTENSIVE ASSISTANCE*)—Patient performed part of activity on own (50% or more of subtasks) *BUT* help of following type(s) provided 3 or more times:
— Weight-bearing support (e.g., holding weight of limb, trunk)
— Full staff performance of a task (some of time) or discrete subtask

5. *MAXIMAL ASSISTANCE*—Patient involved but completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times

6. *TOTAL ASSISTANCE* (*TOTAL DEPENDENCE*)—Full staff performance of activity during entire period

8. *ACTIVITY DID NOT OCCUR*—During entire period

a. BED MOBILITY— How patient moves to and from lying position, turns side to side, and positions body while in bed

b. TRANSFER BED/CHAIR— How patient moves between surfaces—to or from: bed, chair, wheelchair, standing position (**EXCLUDE** to/from bath/toilet)

c. LOCOMOTION—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, how moves once in wheelchair

d. WALK IN FACILITY—How patient walks in room, corridor, or other place in facility

e. DRESSING UPPER BODY—How patient dresses and undresses (**street clothes, underwear**) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.

f. DRESSING LOWER BODY—How patient dresses and undresses (**street clothes, underwear**) from the waist down, includes protheses, orthotics, belts, pants, skirts, shoes, and fasteners

g. EATING—How patient eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

h. TOILET USE—How patient uses the toilet room (or commode, bedpan, urinal); cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes (**EXCLUDE** transfer toilet)

i. TRANSFER TOILET—How patient moves on and off toilet or commode

j. GROOMING/PERSONAL HYGIENE—How patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**EXCLUDE** baths and showers)

k. BATHING—How patient takes full-body bath/shower or sponge bath (**EXCLUDE** washing of back and hair and TRANSFER). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. ***Code for most dependent episode***

l. TRANSFER TUB/SHOWER—How patient transfers in/out of tub/shower ***Code for most dependent episode***

2. ADL ASSIST CODES (Code for most help in last 3 days)

0. Neither code applies 2. 2+ person physical assist
1. Weight bearing support with 1 limb

a. Bed mobility		**g.** Eating	
b. Transfer bed/chair		**h.** Toilet use	
c. Locomotion		**i.** Transfer	
d. Walk in faciility		**j.** Grooming/personal hygiene	
e. Dressing upper body		**k.** Bathing	
f. Dressing lower body		**l.** Transfer tub/shower	

3. ADL CHANGES

a. NUMBER *of ADL areas* (*from* ***E1*** *above*) *in which patient is now more limited in self performance than was prior to precipitating event* (*item* ***A7a***)

b. NUMBER *of ADL areas* (*from* ***E1*** *above*) *in which patient was independent prior to precipitating event* (*item* ***A7a***)

4. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

(In last 24 hours of 3-day assessment period)

CAPACITY TO PERFORM INSTRUMENTAL ACTIVITIES OF DAILY LIVING—if the patient had been required to carry out the activity as independently as possible, SPECULATE AND CODE for what you consider the patient's capacity (ability) would have been to perform the activity

0. *INDEPENDENT*—Would have required no help, setup, or supervision
1. *SETUP HELP ONLY*—Would have only needed article/device placed within reach; patient could have performed on own
2. *SUPERVISION*—Would have required oversight, encouragement, or cuing
3. *LIMITED ASSISTANCE*—On some occasion(s) could have done on own, other times would have required help
4. *MODERATE ASSISTANCE*—While patient could have been involved, would have required presence of helper at all times, and would have performed 50% or more of subtasks on own
5. *MAXIMAL ASSISTANCE*—While patient could have been involved, would have required presence of helper at all times, and would have performed less than 50% of subtask on own
6. *TOTAL DEPENDENCE*—Full performance by other of activity would have been required at all times (no residual capacity exists)

a. MEAL PREPARATION—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)

b. MANAGING FINANCES—Paying for newspaper or TV service, using cafeteria

c. PHONE USE—How telephone calls are made or received (using assistive devices such as large numbers or voice amplification as needed)

d. MEDICATION MANAGEMENT—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, filling syringe, giving injections, applying ointments)

e. STAIRS—How moves up and down stairs (e.g., one flight of steps, using hand rails as needed)

f. CAR TRANSFER—How moves in and out of a car, opening door, sitting, and rising from seat

5. IADL AREAS NOW MORE LIMITED

***NUMBER** of IADL areas (from **E4** above) in which patient is now more limited in self performance than was prior to precipitating event (item **A7a**)*

0. None
1. Some (1-3 IADL areas)
2. All or most (4-6 IADL areas)

6. DEVICES/ AIDS

(***CHECK all that apply***)

LOCOMOTION DEVICES		Mechanical lift	e.
Cane/Crutch	a.	Orthotics/prosthesis	f.
Walker	b.	Postural support (while sitting)	g.
Wheelchair/scooter	c.	Slide board	h.
OTHER AIDS		Other adaptive devices	i.
Adaptive eating utensil	d.	*NONE OF ABOVE*	j.

7. STAMINA

CODE:
0. None
1. Less than 1 hour per day
2. 1 to 2 hours per day
3. 2+ to 3 hours per day
4. 3+ to 4 hours per day
5. More then 4 hours per day

	A Last 24 hours	B Prior
Hours of physical activity at two points in time —examples of physical activity include exercise, therapy sessions, walking, house cleaning, grocery shopping **(A) *in last 24 hours*** *and* **(B) *immediately prior*** *to precipitating event (item **A7a**)*		

8. WALKING AND STAIR CLIMBING

(Note time frame)

a. Farthest distance walked without sitting down **Code for most consistent in last 24 hours**
0. 150+ feet
1. 51-149 feet
2. 25-50 feet
3. 10-24 feet
4. Less than 10 feet
8. *ACTIVITY DID NOT OCCUR*

b. Walking support provided **Code for most consistent in last 24 hours**
0. None
1. Setup help only
2. Supervision
3. One person physical assistance
4. Two+ person physical assistance
8. *ACTIVITY DID NOT OCCUR*

8. WALKING AND STAIR CLIMBING

(Note time frame)

(cont)

c. Stair climbing—Code for most dependent episode when activity attempted in last 24 hours [full flight = 12-14 stairs; partial flight = 4-6 stairs] *There are only three possible codes when patient does 4-6 stairs only* (*code = 2,5,6*)

0. *COMPLETE INDEPENDENCE*—Up and down **full** flight of stairs with NEITHER *physical help* NOR *support device*

1. *MODIFIED INDEPENDENCE*—Up and down **full** flight of stairs with NO *physical help and any of following:*
Use of one or more supportive devices [*support devices* includes the **required** use of hand rails]
OR Use of an appliance (i.e., cane, brace, prosthesis, walker)
OR Excessive time to climb the stairs (3 or more times normal)

2. *SUPERVISION*—Up/down **full** flight of stairs with supervision or cuing -OR- up and down partial flight with NO physical help (device may or may not be used)

3. *MINIMAL ASSISTANCE*—Contact guard/steadying/assistance to go up/down **full** flight of stairs

4. *MODERATE ASSISTANCE*—Some weight bearing help to go up/ down **full** flight of stairs, patient does most on own

5. *MAXIMAL ASSISTANCE*—Patient had limited involvement in going up/down full flight of stairs, staff perform more than 50% of effort -OR- receives physical help on partial flight of stairs

6. *TOTAL ASSISTANCE*—Did not go up/down 4-6 stairs (OR has 2-person assist) OR totally dependent

8. *ACTIVITY DID NOT OCCUR **IN LAST 24 HOURS***

9. BALANCE RELATED TO TRANSITIONS

(Code for most dependent in last 24 hours)

CODE:
0. Smooth transition; stabilizes without assistance
1. Transition not smooth, but able to stabilize without assistance
2. Transition not smooth; unable to stabilize without assistance
8. *ACTIVITY DID NOT OCCUR*

a. Moved from seated to standing position

b. Turned around and faced the opposite direction

10. NEURO-MUSCULO-SKELETAL IMPAIRMENT

(Code for most limited in last 24 hours)

A. (***CODE** for joint mobility/range of motion at joints listed* **(*code for most impaired joint*)**)
0. No impairment
1. Impairment on one side
2. Impairment on both sides

B. (***CODE** for voluntary motor control* (*active, coordinated, purposeful movement - **code for most dependent joint***))
0. No loss
1. Partial loss one side
2. Partial loss both sides
3. Full loss one side
4. Full loss both sides

C. (***CODE** for Intact touch/sensation on extremity, i.e., tactile sense* (**use same codes as E10B**))

	A	B	C
a. Leg (hip, knee, ankle, foot)			
b. Arm (shoulder, elbow, wrist, hand)			
c. Trunk and neck			

SECTION F. BLADDER/BOWEL MANAGEMENT

1. BLADDER CONTINENCE

(Code for last 7-14 days)

a. *Control of urinary bladder function* (*if dribbles, volume insufficient to soak through undergarments*)

0. *CONTINENT* —Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine
2. *BIWEEKLY INCONTINENCE*—Incontinent episodes less than once a week (i.e., once in last 2 weeks)
3. *WEEKLY INCONTINENCE*—Incontinent episodes once a week
4. *OCCASIONALLY INCONTINENT*— Incontinent episodes 2 or more times a week but not daily
5. *FREQUENTLY INCONTINENT*—Tended to be incontinent daily, but some control present (i.e., on day shift)
6. *INCONTINENT*—Has inadequate control of bladder, multiple daily episodes all or almost all of time
8. *DID NOT OCCUR* —No urine output from bladder

b. *Is now more impaired in bladder continence than was prior to precipitating event (item **A7a**)*
0. No or unsure
1. Yes, more impaired today

2. BLADDER APPLIANCE

(Code for last 24 hours)

CODE:
0. No
1. Yes

a. External catheter		**e.** Ostomy	
b. Indwelling catheter		**f.** Pads, briefs	
c. Intermittent catheterization		**g.** Urinal, bedpan	
d. Medications for control			

3. BLADDER APPLIANCE SUPPORT

(Code for last 24 hours)

0. No appliances **(in item F2)**
1. Use of appliances, did not require help or supervision
2. Use of appliances, required supervision or setup
3. Minimal contact assistance (light touch only)
4. Moderate assistance; patient able to do 50% or more of sub-tasks involved in using equipment
5. Maximal assistance; patient able to do 25-49% of all sub-tasks involved in using the equipment
6. Total dependence

4. BOWEL CONTINENCE (Code for last 7-14 days)

0. *CONTINENT*— Complete control, does not use ostomy device
1. *CONTINENT WITH OSTOMY*—Complete control with use of an ostomy device that does not leak stool
2. *BIWEEKLY INCONTINENCE*—Incontinent episodes less than once a week (i.e., once in last 2 weeks)
3. *WEEKLY INCONTINENCE*—Incontinent episodes once a week
4. *OCCASIONALLY INCONTINENT*—2-3 times a week
5. *FREQUENTLY INCONTINENT*—4+ times a week but not all of time
6. *INCONTINENT*—All of time
8. *DID NOT OCCUR*— No bowel movement during the entire 14 day assessment period

5. BOWEL APPLIANCES (Code for last 3 days)

CODE: 0. No 1. Yes

a. Bedpan
b. Enema
c. Medication for control
d. Ostomy

6. BOWEL APPLIANCE SUPPORT (Code for last 24 hours)

0. No appliances **(in item F5)**
1. Use of appliances, did not require help or supervision
2. Use of appliances, required supervision or setup
3. Minimal contact assistance (light touch only)
4. Moderate assistance; patient able to do 50% or more of tasks
5. Maximal assistance; patient able to do 25-49% of all sub-tasks
6. Total dependence

SECTION G. DIAGNOSES

1. IMPAIRMENT GROUP

Refer to manual for coding of impairment group

2. OTHER DISEASES

CODE:
[Blank] Not present
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
[If no disease in list, check **G2aq *None of Above*** item]

ENDOCRINE
a. Diabetes mellitus (250.00)
b. Hypothyroidism (244.9)
HEART/CIRCULATION
c. Cardiac arrythmias (427.9)
d. Congestive heart failure (428.0)
e. Coronary artery disease (746.85)
f. Deep vein thrombosis (451.1)
g. Hypertension (401.9)
h. Hypotension (458.9)
i. Peripheral vascular disease (arteries) (443.9)
j. Post acute MI (within 30 days) (410.92)
k. Post heart surgery (e.g., valve, CABG) (V45.81)
l. Pulmonary embolism (415.1)
m. Pulmonary failure (518.8)
n. Other cardiovascular disease (429.2)
MUSCULOSKELETAL
o. Fracture - hip (V43.64)
p. Fracture - lower extremity (812.40)
q. Fracture(s) - other (829.0)
r. Osteoarthritis (715.90)
s. Osteoporosis (733.00)
t. Rheumatoid arthritis (714.0)
NEUROLOGICAL
u. Alzheimer's disease (331.0)
v. Aphasia or Apraxia (784.3,784.69)
w. Cerebral palsy (343.9)
x. Dementia other than Alzheimer's disease (290.0)
y. Hemiplegia/hemiparesis — left side (342.90)
z. Hemiplegia/hemiparesis — right side (342.90)
aa. Multiple sclerosis (340)
ab. Parkinson's disease (332.0)
ac. Quadriplegia (344.00 - 344.09)
ad. Seizure disorder (780.39)
ae. Spinal cord dysfunction—non-traumatic (336.9)
af. Spinal cord dysfunction—traumatic (952.9)
ag. Stroke (CVA) (436)
PSYCHIATRIC/MOOD
ah. Anxiety disorder (300.00)
ai. Depression (311)
aj. Other psychiatric disorder (300.9)
PULMONARY
ak. Asthma (493.9)
al. COPD (496)
am. Emphysema (492.8)
OTHER
an. Cancer (199.1)
ao. Post surgery - non-orthopedic, non-cardiac (V50.9)
ap. Renal failure (586)
aq. *NONE OF ABOVE*

3. INFECTIONS

CODE:
[Blank] Not present
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
(If no infections, check *NONE OF ABOVE item G3l*)

a. Antibiotic resistant infection (e.g., methicillin resistant staph - (041.11), VRE - (041.9))
b. Cellulitis (682.9)
c. Hepatitis (070.9)
d. HIV/AIDS (042)
e. Pneumonia (486)
f. Osteomyelitis (730.2)
g. Septicemia (038.9)
h. Staphylococcus infection (other than item "G3a") (041.10)
i. Tuberculosis (active) (011.90)
j. Urinary tract infection (599.0)
k. Wound infection (958.3, 998.59,136.9)
l. *NONE OF ABOVE*

4. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9-CM CODES (Any new diagnosis at reassessment or discharge is to be recorded here)

A. *CODE ICD-9-CM diagnosis code*
B. *CODE*:
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment

	A ICD-9-CM	B
a.		
b.		
c.		
d.		
e.		

5. COMPLICATIONS/ COMORBIDITIES

*Code the **ICD-9-CM** diagnostic code. Refer to manual to code comorbidities.*

	DIAGNOSIS	ICD-9-CM
a.		
b.		
c.		
d.		

SECTION H. MEDICAL COMPLEXITIES

1. VITAL SIGNS

Vital signs (*pulse, BP, respiratory rate, temperature*) ***Score for the most abnormal vital sign***
0. All vital signs were normal/standard (i.e., when compared to standard values)
1. Vital signs abnormal, but not on all days during assessment period
2. Vital signs consistently abnormal (on all days)

2. PROBLEM CONDITIONS (In last 3 days)

(***CHECK*** *all problems present in the* ***last 3 days*** *unless otherwise noted*)

FALLS/BALANCE
Dizziness/vertigo/light-headedness **a.**
Fell (since admission or last assessment) **b.**
Fell in **180 days** prior to admission **c.**
CARDIAC/PULMONARY
Advanced cardiac failure (ejection fraction < 25%) **d.**
Chest pain/pressure on exertion **e.**
Chest pain/pressure at rest **f.**
Edema - generalized **g.**
Edema - localized **h.**
Edema - pitting **i.**
Impaired aerobic capacity/endurance (tires easily, poor task endurance) **j.**
FLUID STATUS
Constipation **k.**
Dehydrated; output exceeds input; or BUN/Creat ratio > 25 **l.**
Diarrhea **m.**
Internal bleeding **n.**
Recurrent nausea/vomiting **o.**
Refusal/inability to take liquids orally **p.**
OTHER
Delusions/hallucinations **q.**
Fever **r.**
Hemi-neglect (inattention to one side) **s.**
Cachexia (severe malnutrition) **t.**
Morbid obesity **u.**
End-stage disease, life expectancy of **6 or fewer months** **v.**
NONE OF ABOVE **w.**

3. RESPIRATORY CONDITIONS (In last 3 days)

(***CHECK*** *all problems present in the* ***last 3 days***)

Inability to lie flat due to shortness of breath **a.**
Shortness of breath with exertion (e.g., taking a bath) **b.**
Shortness of breath at rest **c.**
Oxygen saturation < 90% **d.**
Difficulty coughing and clearing airway secretions **e.**
Recurrent aspiration **f.**
Recurrent respiratory infection **g.**
NONE OF ABOVE **h.**

4. PRESSURE ULCERS (Code for last 24 hours)

a. *Highest current pressure ulcer stage*
0. No pressure ulcer **(if no, skip to H5)**
1. Any area of persistent skin redness (**Stage 1**)
2. Partial loss of skin layers (**Stage 2**)
3. Deep craters in the skin (**Stage 3**)
4. Breaks in skin exposing muscle or bone (**Stage 4**)
5. Not stageable (necrotic eschar predominant; no prior staging available)

b. *Number of current pressure ulcers*

SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING—calculate three components (**c** through **e**) and code total score in **f**

c. Length multiplied by width (open wound surface area)
0. 0 cm^2
1. <0.3 cm^2
2. 0.3–0.6 cm^2
3. 0.7–1.0 cm^2
4. 1.1–2.0 cm^2
5. 2.1–3.0 cm^2
6. 3.1–4.0 cm^2
7. 4.1–8.0 cm^2
8. 8.1–12.0 cm^2
9. 12.1–24.0 cm^2
10. > 24 cm^2

d. Exudate amount
0. None 1. Light 2. Moderate 3. Heavy

4. PRESSURE ULCERS (Code for last 24 hours) (cont)

e. Tissue type
0. Closed/resurfaced: The wound is completely covered with epithelium (new skin)
1. Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface
2. Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance
3. Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous
4. Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges

f. TOTAL PUSH SCORE (sum of above three items—**c**, **d**, and **e**)

5. OTHER SKIN INTEGRITY

a. Number of stasis ulcers **in last 24 hours**

b. Number of surgical wounds **in last 24 hours**

c. Ulcer resolved or healed **in last 90 days**
0. No or never had ulcer 1. Yes

6. OTHER SKIN PROBLEMS OR LESIONS PRESENT (Code for last 24 hours)

(***CHECK all that apply***)

Burns (second or third degree)	a.
Open lesions other than rashes, cuts (e.g., cancer lesions, ulcers)	b.
Rashes (e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster)	c.
Skin tears or cuts (other than surgery)	d.
NONE OF ABOVE	e.

SECTION I. PAIN STATUS

1. PAIN SYMPTOMS (In last 3 days)

(***CODE** the **highest level of pain** present in the **last 3 days**, even with treatments* [Note - At minimum, patient must be asked about frequency and intensity])

a. FREQUENCY with which patient complains or shows evidence of pain
0. No pain 2. Daily - single shift
1. Less than daily 3. Daily - multiple shifts

b. INTENSITY of pain
0. No pain 2. Moderate 4. Times when pain is horrible
1. Mild 3. Severe or excruciating

c. Current pain status as compared to pain status prior to precipitating event (item **A7a**)
0. Same 1. Better 2. Worse 8. UNKNOWN

SECTION J. ORAL/NUTRITIONAL STATUS (In last 3 days)

1. ORAL PROBLEMS

CODE: 0. No 1. Yes

a. Chewing problem (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control)

b. Dental problems (e.g., ill-fitting or lack of dentures, painful tooth, poor dental hygiene)

2. SWALLOWING

0. *NORMAL*—Safe and efficient swallowing of all diet consistencies
1. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only)
2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids)
3. *COMBINED ORAL AND TUBE FEEDING*
4. *NO ORAL INTAKE* (*NPO*)

3. HEIGHT AND WEIGHT

*Record (**a.**) **height in inches** and (**b.**) **weight in pounds**. Base weight on most recent measure in **last 3 days**; measure weight consistently in accordance with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*

a. HT (inches) **b.** WT (pounds)

4. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**
0. No or unknown 1. Yes, planned loss 2. Yes, unplanned loss

b. Weight gain—5 % or more in **last 30 days**
0. No or unknown 1. Yes, planned gain 2. Yes, unplanned gain

5. PARENTERAL OR ENTERAL INTAKE

a. The proportion of **total calories** the patient received through parenteral or tube feedings in the **last 3 days**
0. None 3. 51% to 75%
1. 1% to 25% 4. 76% to 100%
2. 26% to 50%

b. The average **fluid intake** per day by IV or tube in **last 3 days**
0. None 3. 1001 to 1500 cc/day
1. to 500 cc/day 4. 1501 to 2000 cc/day
2. 501 to 1000 cc/day 5. 2001 or more cc/day

SECTION K. PROCEDURES/SERVICES (In last 3 days)

1. CLINICAL VISITS AND ORDERS

*Services in **last 3 days***

a. Total number of physician visits (by attending, consultant, etc.) in which patient was examined and MD notes written

b. Number of times **physician or nurse practitioner** called to bedside for emergency—e.g., cardiorespiratory arrest, hemorrhaging, to evaluate change in condition

c. Number of **nurse practitioner** visits in which patient examined and notes written

d. Number of **physician assistant** visits in which patient examined and notes written

e. Number of **new or changed orders**

2. TREATMENTS AND SERVICES

A. Over the last 3 days, code for *treatment frequency* [*either daily* (*code 3*) *or less than daily* (*code 2*) or ordered, not yet implemented (code 1)] (**If no treatments provided or ordered, check *NONE OF ABOVE item K2ai***)

[*Blank*] Did not occur, not ordered 2. Less than daily
1. Ordered, not yet implemented 3. Daily

B. *RECORD AT DISCHARGE ASSESSMENT ONLY* (**A3 = 5**), *record whether patient will receive service after discharge*
[*Blank*] No 1. Yes

	A	B
MEDICATION RELATED		
a. Diabetic management		
b. Injections		
c. IV antibiotics/meds		
SKIN TREATMENT		
d. Application of dressings		
e. Application of ointments, topical medications		
f. Debridement (chemical or surgical)		
g. Nutrition/hydration intervention to manage skin problems		
h. Pressure relieving bed/chair		
i. Turning and repositioning		
j. Ulcer care		
k. Wound care - surgical		
MANAGEMENT OF HEALTH PROBLEMS		
l. Bladder training		
m. Scheduled toileting		
n. Bowel program		
o. Cardiac monitoring/rehabilitation		
p. Cast(s)		
q. Continuous or bi-level positive airway pressure (CPAP or BiPAP)		
r. Drains (cutaneous drains and other drains)		
s. Dialysis		
t. Enteral feeding tube		
u. IV line - central		
v. IV line - peripheral		
w. NG feeding tube		
x. Oxygen		
y. Pain management - other than drugs		
z. Suctioning - oral/nasopharyngeal		
aa. Suctioning - tracheal		
ab. Tracheostomy care		
ac. Transfusion(s)		
ad. Ventilator or respirator		
ae. Ventilator weaning		
OTHER		
af. Family training in assistance to patient in health measures or skills required after return to community		
ag. Patient training in health maintenance or skills required after return to community		
ah. Design and implementation of discharge plan		
ai. *NONE OF ABOVE*	ai.	ai.

3. NURSING PRACTICE OR RESTORATIVE CARE

*Record the NUMBER OF DAYS each of the following restorative or practice techniques was **provided to the patient for more than or equal to a total of at least 15 minutes per day in the last 3 days** (Enter 0 if none or less than 15 min. daily)*

a. Range of motion (passive)		**f.** Transfer	
b. Range of motion (active)		**g.** Walking	
c. Splint/orthotic assistance		**h.** Dressing or grooming	
TRAINING AND SKILL PRACTICE IN		**i.** Eating or swallowing	
d. Bed mobility		**j.** Amputation/prosthesis care	
e. Bladder/bowel		**k.** Communication	

4. THERAPY SERVICES (By qualified therapist or therapy assistant under direction of therapist)

*Over the **last 3 days**, record the number of days and total minutes each of the following therapies was ordered* **[A]** *administered* **[B]** *(for at least 15 minutes a day) (Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]
A. # of days treatment ordered during the **last 3 days [MAX=3]**
B. # of days administered for **15 minutes or more [MAX=3]**
C. total # of minutes provided in **last 3 days** (or *ordered* if days administered = 0 and days ordered > 0)

D. *RECORD AT DISCHARGE ASSESSMENT* (***A3 = 5***), *record whether patient will receive service after discharge*
0. No 1. Yes

	DAYS Ordered A	DAYS Administered B	Minutes Delivered C	Post Discharge D
a. Speech - language pathology and audiology services				
b. Occupational therapy				
c. Physical therapy				
d. Respiratory therapy				
e. Psychological therapy (by any licensed mental health professional)				
f. Therapeutic recreation				

5. DEVICES AND RESTRAINTS

(*USE THE FOLLOWING **CODES** FOR **LAST 3 DAYS***)
0. Not used
1. Used less than daily
2. Daily use - night only
3. Daily use - days only
4. Night and day, but not constant
5. Constant use for full 24 hours (with periodic release)

a. Full bed rails on BOTH open sides of bed	
b. Other types of side rails used (e.g., half rail, one side)	
c. Trunk restraint	
d. Chair prevents rising	

SECTION L. FUNCTIONAL PROGNOSIS

1. FUNCTIONAL IMPROVEMENT GOALS

(Code for last 24 hours)

*For **all but discharge assessment**—code for clinical staff expectations of patient goals in the areas listed below by time of discharge.*

*For **discharge assessment**, code for staff expectation of patient functional goal in the post discharge period.*

0. No goal exists
1. Goal-improvement, full recovery to premorbid status anticipated
2. Goal-improvement, partial recovery anticipated
3. Goal-improvement, recovery uncertain
4. Goal-maintenance, prevention of further decline

ADLs			
a. Bed mobility/transfer		**e.** Toileting	
b. Dressing		**OTHER**	
c. Eating		**f.** Medication management	
d. Locomotion		**g.** Pain control	
		h. Managing finances	

2. ATTRIBUTES RELEVANT TO REHABILITATION

CODE: 0. No 1. Yes 8. UNKNOWN

a. Patient believes he/she is capable of increased independence	
b. Patient unable to recognize new limitations	
c. Patient fails to initiate or to continue to carry out ADLs (once initiated) for which he/she has some demonstrated capability	

3. CHANGE OVER LAST 3 DAYS

CODE:
0. Improved
1. About the same as at admission (or last assessment if this is not an admission assessment)
2. Worse

a. Change in overall **functional status** over **last 3 days**	
b. Change in overall **health status** over **last 3 days**	

4. ESTIMATED LENGTH OF STAY FROM DATE OF ADMISSION

*How long patient is expected to stay in current setting prior to return to community (**count from date of admission in item A2, including that day**)*

0. 1-6 days
1. 7-13 days
2. 14-30 days
3. 31-90 days
4. 91 or more days
5. Discharge to community not expected
6. Expected discharge will be to another health care setting - prior to return to community

SECTION M. RESOURCES FOR DISCHARGE

1. AVAILABLE SOCIAL SUPPORTS

(Family/close friends)

CODE: 0. No 1. Possibly yes 2. Definitely yes

*Presence of one or more family members (or close friends) who are **willing and able** to provide support after discharge*

a. Emotional support	
b. Intermittent physical support with ADLs or IADLs — less than daily	
c. Intermittent physical support with ADLs or IADLs — daily	
d. Full time physical support (as needed) with ADLs or IADLs	
e. All or most of necessary transportation	

2. CAREGIVER STATUS

CODE: 0. No 1. Yes

a. Family (or close friend) overwhelmed by patient's illness	
b. Family relationship(s) require unusual amounts of staff time	

3. LIVING ARRANGEMENT

A. ***CODE** for **permanent** living arrangement **prior to admission***
B. ***CODE** for **permanent** arrangement expected **at discharge** or actual discharge site if this is a discharge assessment* (**A3=5**)
C. ***CODE** for **initial** arrangement expected at discharge—if different than column **M3B*** (otherwise, leave blank) or actual discharge site if this is a discharge assessment (**A3=5**)

	A Prior to adm	**B Perm disch**	**C Temp disch**
a. Type of residence			
0. UNKNOWN			
1. Private home			
2. Private apartment			
3. Rented room			
4. Board and care/assisted living/group home			
5. Homeless (with or without shelter)			
6. Long-term care facility (nursing home)			
7. Post acute care SNF			
8. Hospice			
9. Acute unit/hospital			
10. Other			
b. Live(d) with			
0. UNKNOWN			
1. Alone			
2. Spouse only			
3. Spouse and other(s)			
4. Child (not spouse)			
5. Other relative(s) (not spouse or children)			
6. Friends			
7. Group setting			
8. Personal care attendant			
9. Other			